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IN PATIENTS UNDERGOING OUTPATIENT SURGERY

A Thesis

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In Partial Fulfillment

of the Requirements for the Degree

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in

Nursing

by

Lee Ann Sheehan

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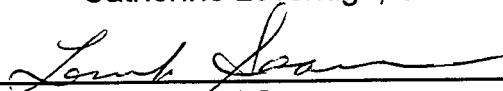
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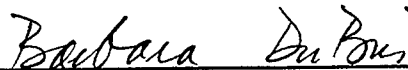
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Spring 1997

DEDICATION

This thesis is dedicated to my daughters, Lisa Marie and Kristin Lee, who tolerated my many nights at the computer and never complained about my preoccupation with school work. I can only hope that in future years when they have read this study, it serves as a source of inspiration when grappling with their own educational aspirations.

This thesis is also dedicated to my parents, John Dale and Ruth Elizabeth, who somewhere along the way, instilled in me the values of tenacity and hard work. Both values are a necessity for anyone undertaking a graduate program.

And finally, I'd like to offer a special dedication to my sister, Lisa Banning, who was a reservoir of emotional support during a very demanding time in my life. Your willingness "to be there" when I needed help was deeply appreciated.

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CHAPTER I

INTRODUCTION

By the year 2020, it is expected the senior population, 65 and older, will constitute 15.5% of the total U.S. population, or 45 million people (Doty, Korfin, & Weiner, 1985). Within this group, those 85 and older are the fastest growing population segment with improved medical care and technology largely responsible for their increased longevity (Feldstein, 1993). A natural outcome of this longevity is the need to manage both acute and chronic illnesses for this patient population and the costs associated with their care.

Medicare, the nation's primary source of medical insurance for individuals 65 and older, is the nation's single largest payor of health care services (Melillo, 1996). Recent changes in Medicare reimbursement and the proliferation of managed care organizations have enabled the federal government to offer alternative medical care coverage for the elderly such as Senior Health Maintenance Organizations (HMOs) (Sharp, 1995). Under the new Medicare Select program, beneficiaries may enroll in HMOs designed specifically for the seniors; however, seniors are restricted to providers within their network. Additionally, seniors are managed medically according to HMO practice

standards. HMOs have historically controlled their costs through fewer hospital admissions, shorter hospital stays and a greater reliance on outpatient services (Feldstein, 1993). As a result of this trend toward outpatient services, increasing numbers of seniors are undergoing surgery on an outpatient basis (McGovern & Newbern, 1988).

This trend toward outpatient services, coupled with advancements in drug therapy and surgical techniques, have created surgical opportunities for patients previously considered at risk for anesthesia (Catlic, 1985). One such population are the seniors, 65 and older. Through the development of short acting anesthetics and less invasive surgical techniques, surgeons are able to treat these patients on an outpatient basis while maintaining positive medical outcomes (Kelly, 1995). Examples of outpatient surgeries commonly performed on this population include laparoscopic procedures and hernia repairs. In the previous decade, these surgeries often resulted in inpatient admissions averaging 4-7 days (Legorreta, Silber, Costantino, Kobylinski, & Zatz, 1993). Today, these procedures are routinely performed on an outpatient basis provided patients are medically eligible.

According to Kelly (1995), approximately 50% of those over the age of 65 will undergo an operative procedure in their remaining lifetimes, and many of these will be on an outpatient basis. Although the aged patient may be physically stable for discharge to home, postoperative care may be required for several days in the areas of routine activities, pain management, signs

and symptoms, and anxiety (Frisch, Groom, Seguin, Edgar, & Pepler, 1990). Successful surgical outcomes will require the nurse to thoroughly assess the discharge planning needs from the perspective of both the patient and their support system.

Elderly patients, by virtue of the aging process and the increased incidence of chronic health problems, are particularly at risk for prolonged recoveries. Assessment and attention to the educational, psychological, and emotional needs of the patient, as well as their support systems, are imperative to successful surgical outcomes (Congdon, 1994). Through joint collaboration of professionals, patients, and their support systems, realistic and acceptable goals can be set to facilitate recovery in the home environment. Since most research in the area of social support and coping among the aged has focused on adaptation to chronic illness and inpatient surgical care (Friedman, 1993; Johnson, 1996; Ortega, Metroka, & Johnson, 1993), research in the outpatient setting is needed. This study will focus on the outpatient surgical setting and the relationship between these two concepts. The information gained from this project will aid nurses in effectively guiding patients through the recovery process.

Theoretical Framework

The constructs of social support and coping have been well-researched throughout the medical and social science literature. The elderly

are often the subject of such studies. However, chronic illness and major medical episodes have garnered most of the attention in this area of study (Berkman, Leo-Summers, & Horwitz, 1992; Cummings et al., 1988; Wilcox, Kasl, & Berkman, 1994). In general terms, the literature suggests an adequate level of social support is positively correlated with adaptation (coping) to illness in a broad category of circumstances and patients (Johnson, 1996; McNaughton, Smith, Patterson, & Grant 1990; Wilcox, 1981). Despite the paucity of research addressing social support and coping behaviors in the ambulatory care environment, the literature provides many examples of this relationship in other settings. The themes from these other care settings will form the theoretical foundation for this study on elderly patients undergoing surgery on an outpatient basis.

Kahn (1979) contends social support is composed of interpersonal transactions of positive expression, affirmation of one's beliefs by others, and the giving of symbolic or material aid to another. He also suggests that social support is viewed in the context of a "person-environment fit." This relationship refers to the difference or "fit" between the demands of the individual and the available environmental resources. The adequacy of support is evaluated in terms of successful transactions between the person and the environment at any given time. These transactions or linkages occur within the framework of an individual's network or set of significant others with whom the individual exchanges social support.

According to Caplan (1974) social support systems consist of continuing social aggregates that provide individuals with opportunities for feedback about themselves and validations of their expectations for others. These supporters provide emotional sustenance, tangible resources and aid, and information and cognitive guidance in times of need. By providing emotional sustenance, supporters help individuals master their own emotional problems by mobilizing their own psychological resources. By providing the person with tangible aid, resources, and information, they enhance one's ability to cope with a stressful situation.

Lazarus, Averil, and Opton (1974) view coping as a strategy for managing stress. It consists of two aspects, an externally directed one and an internally directed one. External coping is judged for effectiveness in social terms and internal directed coping, or defensive coping, serves to protect one from the disruptive degrees of anxiety. It is judged for adequacy by the degree of comfort attained.

Coping serves two functions, namely managing or altering a problem (stress) with the environment (problem-focused coping), and regulating the emotional response to a problem (emotion-focused coping). Problem-focused coping is directed at defining the problem, generating alternative solutions, weighing the alternatives in terms of costs and gains, choosing among them, and acting (Lazarus & Folkman, 1984). Emotion-focused forms of coping are generally associated with an appraisal that nothing can be

done to modify harmful, threatening, or challenging conditions. Emotion-focused coping attempts to manage or “buffer” the emotions aroused by stressors, thereby maintaining emotional equilibrium (Lazarus & Folkman, 1984).

In adjusting to stressful life events, Wethington and Kessler (1986) found perceived support from one’s network is, in general, more important than actual support in predicting coping success. Actual support is an important element in promoting psychological adjustment (coping), but perceptions of that support either enhance or detract from its beneficial effects. Cobb (1976) validates the relationship between social support and coping by his report on physical and psychological illnesses. He found coping behavior was strengthened with adequate social support by reducing the amount of pain medication used, accelerating the recovery process, and enhancing compliance with prescribed medical regimens. Further, Wilcox (1981) believes social support at higher levels functions to “buffer” psychological distress and protect people from the deleterious effects of stressful life events.

Wilcox et al. (1994) found social support, in the form of practical tasks, facilitated recovery and aided the elderly in coping with a major medical event. In a study addressing the specific role of social support in the elderly, Johnson (1996) found older rural adults who had lower levels of social support also exhibited poorer health. Conversely, greater levels of social

support were correlated with better health. It was theorized that the forced isolation incurred by this population as a result of physical limitations and inclement weather, impacted their ability to obtain needed support. And finally, Kulik and Mahler (1993) found that patients who reported higher emotional support during an illness episode, experienced better overall coping with their disability. The respondents also reported a better overall quality of life, and complied more with behavior recommendations.

As illustrated above, the constructs of social support and coping behavior are intimately linked throughout the health literature. Adequate social support promotes successful adaptation to life's stressors (Callaghan & Morrissey, 1993; Cobb, 1976; Kahn, 1979; Preston & Grimes, 1987), and successful coping behaviors are the beneficiary of adequate support levels (Johnson, 1996; Pakenham, Dadds, & Terry, 1994; Thoits, 1986). In the case of the patient undergoing outpatient surgery, it is a reasonable conclusion that those patients with greater social support will cope more effectively with their outpatient surgical procedure.

Hypothesis

Outpatient surgery clients with greater levels of social support will cope more effectively with their surgical procedure and, thus, recover more rapidly than patients with lower levels of social support.

Operational Definitions

Social Support

Social support is the independent variable and is defined as the degree to which the individual's needs for socialization, tangible assistance, cognitive guidance, social reinforcement, and emotional sustenance are met through interaction with their social network. For the purposes of this study, social support will be measured by the Norbeck Social Support Questionnaire (NSSQ) (Appendix A).

Coping

Coping is the dependent variable and is defined as psychological strategies of both conscious and unconscious dimensions used to overcome stressful situations and return an individual to an emotional state of equilibrium. These strategies include both problem-focused strategies and emotion focused strategies. For the purposes of this study, coping will be measured by the Jalowiec Coping Scale (JCS) (Appendix B).

Outpatient Surgery

Outpatient surgery is defined as surgical procedures performed on an outpatient basis with discharge from the hospital or surgicenter within a 23 hours and 59 minutes timeframe. The term outpatient surgery is synonymous with "major ambulatory surgery," as operations performed on nonhospitalized

patients under any anesthesia for which a period of postoperative recovery (or observation) is required or advisable. This is contrasted with minor ambulatory surgery which is performed under local anesthesia with immediate discharge of the patient. For the purposes of this study surgery cases will include procedures performed within the abdominal cavity such as hernia repair, appendectomies, and cholecystectomies.

Patient

For the purposes of this study, patient is defined as an individual age 65 or older and male.

Delimitations

For the purposes of this study, subjects will be limited to male patients, 65 years of age, or older, undergoing surgery in the outpatient setting. The decision to exclude female patients is based on the work of Johnson (1996) and Preston and Grimes (1987). These researchers found significant differences in the use of social support systems between males and females. Females often relied on people external to the marriage for social support, whereas males tended to rely heavily on their spouses for support in times of crisis. This difference in behavior was theorized to result from the cultural conditioning of men and women with men socialized to be providers and women socialized to be nurturer. In Johnson's (1996) study which

specifically addressed the elderly population, widowers over 75 years old had the least social support and poorest health. Younger, elderly, married women had larger social support networks, higher levels of support, and better physical health. Based on these qualitative differences in the use of social support networks between the two sexes, women will be excluded from this study. Surgical procedures will be limited to hernia repair, cholecystectomies, and appendectomies since their invasiveness and recovery periods are similar (Legorreta et al., 1993). Subjects excluded from this study will be those with diabetes mellitus (insulin dependent) due to the impact this disease has on the healing process, subjects with severe COPD, patients unable to ambulate, and subjects with cognitive impairments. Subjects must be proficient in speaking and writing in English.

CHAPTER II

REVIEW OF THE LITERATURE

The concepts of social support and coping have been the subjects of numerous studies and professional papers in both the social science literature and human sciences. In some cases these concepts have been studied as the primary topic of interest (Folkman & Lazarus, 1980; Kahn, 1979), and in other studies these two concepts have been studied as they relate to one another (Holahan, Moos, Holahan & Brennan, 1995; Kvam & Lyons, 1991; Pakenham et al., 1994). The review of the literature for this study will include previous work on social support and coping as primary areas of interest with the final review focusing on these concepts as they interrelate with one another.

Social Support

Social support, as a concept, has been widely researched during the past decade and reveals itself to be a diffuse, multifaceted concept for which only partial agreement exists as to its precise meaning. Kahn (1979), defines social support as interpersonal transactions that include one or more of the following: the expression of positive affect of one person toward another; the

affirmation or endorsement of another person's behaviors, perception or expressed views; and the giving of symbolic or material aid to another.

Social support is viewed in the context of a "person-environment fit," and the adequacy of support is identified as the function of the transaction between the person and the environment at any given time. These transactions or linkages occur within the framework of the individual's network, or set of significant other people, to whom the individual gives or receives social support. These relationships are not all symmetrical and there are overlaps where one or both may give and receive support.

In a study on the buffering effects of social support, Wilcox (1981) found support for his hypothesis that social support mediates or "buffers" the relationship between life events and psychological distress. Wilcox administered two measures of support, the Social Support Index and Social Support Questionnaire; two psychological distress scales, the Profile of Mood States-Tension subscale and a brief version of the Psychiatric Epidemiology Research Interview; and a stressful life events scale, the Langer Symptom Checklist, to 320 randomly selected community residents, 18 years of age or older. The results suggested that both the quantity and quality of social support positively effect the stressful life events-psychological distress relationship. Further, between the two (quantity & quality), the quality of social support demonstrated a stronger relationship on one's ability to adjust to psychological distress. A major limitation of this study was the assessment

of social support at one point in time. A longitudinal design to measure social support might provide a more complete picture since support networks change over the course of one's lifetime (Cobb, 1976).

Johnson (1996) studied the effects of support systems on the general health status of the rural elderly. The sample population consisted of 82 randomly selected older adults ranging between the ages of 64 to 98 years. Respondents had to live in an isolated western rural community with a population of less than 2,500 or on a farm or ranch. Using the Personal Resource Questionnaire (PRQ85) respondents were asked to rate their satisfaction with available social support in a variety of circumstances and to rate their relational perceptions of social support. A strong positive correlation was made between reported higher levels of social support and the perception of good health. Additionally, the findings suggested that younger married women had larger social support networks, higher levels of overall support, and better physical health than the remaining participants. Widowers over 75 years old had the least social support and poorest health. The authors also suggested rural aged are qualitatively different from urban aged; therefore, these findings must be limited to the rural elderly only. With this distinction made, generalizing these findings to other rural populations must be done so with caution due to the relatively small sample size.

Socioemotional support and support in the form of instrumental aid formed the foundation of a study of the elderly by Preston and Grimes

(1987). These researchers randomly selected 900 elderly, aged 65 years and older through telephones exchanges in six northeastern states. The sample consisted of 35% ($N = 311$) male and 65% ($N = 589$) female. Once appropriate subjects agreed to participate in the study, interviews were conducted over the phone using a structured questionnaire. The data were analyzed by gender and marital status of the subjects. The results of the study indicated significant differences in the patterns of social support for elderly on both gender and marital status. Further, the study suggested married men rely more heavily on spouses for socioemotional and instrumental support whereas married females tended to rely on family and friends to fulfill their needs. Among the unmarried subjects, there were no significant differences in socioemotional support between male and females; however, unmarried females used more instrumental aid (helping networks) than their male counterparts. The strength of this study was the design and method of sample selection which permits greater generalization to other noninstitutionalized aged populations.

Hubbard, Muhlenkamp, and Brown (1984) studied the effects of social support on self-care practices in two separate populations, identified as Study I and Study II. In Study I, 97 volunteers were recruited from a Southwest metropolitan area senior citizen's center. Fifty-seven were females and 40 were males ranging in ages between 55-90. Subjects were administered the Personal Resources Questionnaire (PRQ), Part II to measure social

support, and the Lifestyle Questionnaire to measure six kinds of positive health practices. The results of Study I showed significantly higher levels of perceived support among married participants than nonmarried respondents, and single individuals perceived themselves as the least supported. Older age in respondents was positively related to Lifestyle scores, and for all variables affecting positive health behaviors, social support emerged as the most significant indicator accounting for 14% of the variance in the Lifestyle Questionnaire.

Hubbard et al. (1984), in Study II, administered the same two instruments to 133 individuals attending a health fair in a large metropolitan shopping center. Fifty-eight of the respondents were female and 73 were male; two did not specify their sex. Ages ranged from 15 to 77 years with a mean of 44 years. In this population marital status did not make a difference in either perceived level of social support or the number of health practices performed by the individuals. Overall, females scored higher in health practices and social support than did males; however, in contrast with Study I, age was not a significant contributor to Lifestyle scores. Again, social support was the most significant indicator and accounted for 34% of the variance in positive health practices. The importance of social support on positive health behaviors is demonstrated by these two divergently different populations. The ability to generalize these findings to other populations is

limited by the homogeneity of Study I respondents and the nonrandom sampling of both study groups.

Wilcox et al. (1994), performed a secondary analysis on 171 women and 98 men ages 65-97 years from a cohort of the Established Populations for Epidemiologic Studies of the Aging (EPESE) and the Recovery Substudy of the New Haven EPESE. The EPESE, a longitudinal study funded by the National Institute on Aging, is designed to identify predictors of mortality, morbidity, institutionalization, and disability in the elderly. Subjects are adults age 65 and over who are periodically interviewed about their physical, psychological, and social support functioning. In this study, hospital admissions of cohort subjects were monitored for myocardial infarction (MI), stroke, and hip fracture between the years 1982 to 1988. Interviews with 269 subjects (84 hip fracture cases, 79 stroke cases, and 106 MI cases) were conducted in their homes at 6 weeks and 6 months post-hospitalization. Premorbid data were taken from the baseline EPESE interviews. The results of this study suggested that illness may precipitate changes in qualitative and quantitative aspects of social support in the aged. Specifically, the percentage of people reporting "no one to count on" for emotional and financial support increased from before to after hospitalization. Post-hospitalization, the number and sources of emotional support increased without any corresponding improvement in the adequacy of that support. Another finding significant for this population was the effect practical support had on the

aged. In contrast with evidence from a previous study that suggested practical support may impede the recovery process (Brickman et al., 1982), this study found the benefits of practical support outweighed any potential harm with elderly survivors of a major medical event. The unique contribution of this study is that it examined these issues by means of a methodology that included both premorbid and post-illness measures of social support while controlling for both illness severity and prior health status.

Coping

Coping is defined as a problem solving effort made by an individual when the demands of a situation are highly relevant to their welfare and the demands are appraised as taxing their adaptive resources (Lazarus et al., 1974). Coping is a strategy for managing stress and can be viewed as consisting of two aspects, an externally directed one and an internally directed one. Externally directed coping is judged for its effectiveness by whether or not an individual is able to fulfill responsibilities, and internally directed, or defensive coping, serves to protect an individual from anxiety. Internally directed coping is judged for its adequacy by the degree of comfort attained. Coping efforts affect the adaptational outcomes of individuals over the course of their lifetimes (Lazarus et al., 1974).

In a study analyzing the coping strategies of 100 community-residing men and women, Folkman and Lazarus (1980) evaluated the coping

strategies associated with the events of daily living over a one-year period. Information about recently experienced stressful encounters was elicited through monthly interviews, and self-reports questionnaires completed between interviews. At the end of each interview and questionnaire, the participant indicated on a 68-item Way of Coping checklist those coping thoughts and actions used in the specific encounter. Two functions of coping, problem-focused and emotion-focused, were analyzed with separate measures. The findings suggested both problem and emotion-focused coping were used in 98% of the 1,332 episodes, emphasizing coping as a function of both problem and emotion-focused processes. Additionally, the context of an event and how it is appraised emerged as important factors in determining coping style. Work contexts favored problem-focused coping, and health contexts favored emotion-focused coping. Similarly, situations in which the person thought something constructive could be done, or that required more information, favored problem-focused coping. Those situations that needed to be accepted favored emotion-focused coping. Generally speaking, men used more problem-focused coping in work situations, situations having to be accepted, and situations requiring more information. There were no gender differences found in one's tendency to use emotion-focused coping.

Pakenham et al. (1994) studied the coping styles of 96 HIV positive individuals and their adjustment to this diagnosis. The subjects were

classified into four mutually exclusive groups based on the level of infection and were assessed using several instruments, including a problem checklist, the Social Support Resources Scale, a coping strategy device which used cards to rank coping choices, a global health rating instrument, the Brief Symptom Inventory tool, and the Psychosocial Adjustment to Illness Scale. With respect to the impact of coping strategies on adjustment to HIV infection, the authors concluded optimism, control, action, and interpersonal coping strategies were associated with low levels of global distress and illness-related psychological distress. On the other hand, fatalism was related to poor perceptions of global health. Of the various coping strategies under investigation, a problem-focused coping strategy was the most strongly related to low levels of distress.

Pollock, Christian, and Sands (1990) studied the effects of 211 adults coping in middle-age with three chronic illnesses, namely rheumatoid arthritis, hypertension, and multiple sclerosis. Subjects were administered instruments to measure physiologic adaptation for each diagnostic group; the Mental Health Index (MHI), the Health-Related Hardiness Scale (HRHS), to measure for the hardiness characteristic in the chronically ill; the Margin in Life Scale (MIL), to measure the individual's ability to tolerate life changes; and a demographic questionnaire. The authors concluded physiologic adaptation was significantly different among the three chronic illnesses; however, psychologic adaptation (coping) did not differ among the groups.

These findings suggest that although each chronic illness has disease-specific physiologic changes, the nature of the psychological adaptation (coping) process is similar. Additional findings suggest the length of time with a chronic illness is related to more physiologic problems, but not with changes in psychological status. The hardiness characteristic was the only major variable that related to both physiologic and psychological adaptation and lends further support for the direct effects of hardiness on adaptation to chronic illness. Hardy persons were more likely to engage in health-related activities and these activities were related to better physiologic adaptation. Narsavage and Weaver (1994) found similar support for the effects of the hardiness characteristic in a study on psychological status, coping and hardiness as predictors of outcomes in patients with Chronic Obstructive Pulmonary Disease (COPD). Weaknesses in the Pollock et al. (1990) study are derived from the study's method of sample selection, a nonrandom, convenience sample, and the element of patient perception when filling out objective questionnaires on the meaning of health.

Terry (1992) conducted a longitudinal study of 40 patients, primarily males (87.5%) ranging in ages from 34-69, from two public hospitals. The purpose of this study was to examine the utility of a set of variables derived from the stress and coping literature as correlates of patients' level of psychosocial adaptation to a myocardial infarction (MI). Data were collected soon after the patients' discharge from the hospital and 3 months after the MI

event. It was proposed that the high level of perceived stress associated with the infarct, and the use of emotion-focused coping strategies, would be associated with poor adaptation to the event. Conversely, it was hypothesized that the use of problem-focused strategies, high levels of self-efficacy, access to the appropriate personal (control beliefs, self-esteem and trait anxiety), and social (marital and family quality) coping resources would facilitate adaptation. There was only weak support for the proposed effects of perceived stress, and no support for the proposal that the use of problem-focused strategies would facilitate the adaptation of infarct patients. In contrast to these findings, the data provided some support for the hypothesized effects of self-efficacy and emotion-focused coping strategies. There was also evidence to suggest that adaptation to an infarct was facilitated if subjects had internal control beliefs, high self-esteem, low trait anxiety, and high-quality family relations. Contrary to expectations, marital quality was largely unrelated to the measures of adaptation. To strengthen the findings of this study, future research might consider a larger sample size to examine which variables (perceived stress, self-efficacy, coping, or coping resources) emerge as distinctive predictors of post-infarct adaptation, when all the predictors are considered simultaneously.

To assess the coping strategies of patients undergoing outpatient surgery for the first time, Caldwell (1991) evaluated the preference for information preoperatively as it related to the coping process. Data were

collected from a convenience sample of 69 subjects undergoing outpatient surgery for the first time in a large Northeast teaching hospital. A major qualifier for this study was the requirement that this be the subject's first outpatient surgery experience. Subjects were administered three scales, the Krantz Health Opinion Survey which measured preference for information in routine short-term illnesses; the Spielberger State-Trait Anxiety Inventory; and the Revised Ways of Coping Checklist. Data were collected before the operative procedure. Findings of this study suggested surgical outpatients with a higher preference for information had lower levels of preoperative stress and coped more effectively. However, too much information for those with a low preference resulted in less effective coping as evidenced by higher stress levels.

Other significant findings of this study included the evaluation of the types of coping strategies utilized by the subjects. Specifically, this study evaluated the use of problem-focused coping and emotion-focused coping in the subjects. The authors concluded that the use of problem-focused coping was relatively low for the entire population probably because the decision to have surgery was already made and little could be done about it preoperatively. Conversely, there was a significant positive relationship between anxiety and emotion-focused coping strategies preoperatively. In conclusion, the study found outpatient surgery requires most patients to cope in

numerous and varied ways, but the greater percentage of preoperative coping efforts are directed at controlling emotional reactions.

Several methodological factors limited the application of these findings to other populations. The authors used a convenient sample from one facility and stipulated that subjects be limited to those undergoing outpatient surgery for the first time. It may be beneficial for future studies to compare groups with and without experience with outpatient surgery. Additionally, the study included a disproportionate number of females to males with 70% of the subject ranging in ages between 19 and 39. It is documented in the literature that males cope differently with stress than females (Preston & Grimes, 1987). Analysis of anxiety and coping strategies by age groups and gender may have been more illuminating.

Social Support and Coping

Social support in conjunction with coping are two major constructs that have been researched in the chronic illness and inpatient treatment literature. Both appear to be helpful in explaining differences in the quality of life after a diagnosis is made and treatment is initiated. These constructs, therefore, warrant investigation in the context of the elderly undergoing surgery in an outpatient setting.

Kvam and Lyons (1991) studied the relationship between coping strategies and social support in 51 subjects enrolled in an outpatient diabetes

mellitus educational program. Subjects were evaluated for their styles of coping, perceptions of social support, and feelings of well-being using the Folkman-Lazarus Way of Coping Checklist, the Perceived Social Support questionnaire, and the Rand Health Insurance Study-General Well-Being Schedule. The results of this study suggested men use more problem-focused coping, whereas women rely more heavily on wish fulfillment coping strategies. Additionally, men perceived greater support from family while women reported more support from friends. These findings are consistent with other studies that cite the differences in perceptions of social support between men and women (Johnson, 1996; Preston & Grimes, 1987). Finally, the authors evaluated the differences between the types of diabetes, insulin-dependent, and noninsulin dependent, and found noninsulin dependent subjects believed they received significantly more support from friends. This finding may be attributed to relatively minor impact diet-controlled or oral hypoglycemic controlled diabetic treatment has on other members of a support network. To further strengthen the results of this study, investigators might consider using random sampling from a variety of health care settings and assess for psychological differences between the different types of diabetic patients.

Pakenham et al. (1994) studied the relationship between social support and coping and its impact on adjustment to individuals diagnosed as HIV positive. Ninety-six HIV-infected gay men and 33 seronegative

comparison group subjects participated in the study. Subjects were recruited through outreach within gay and HIV communities and were administered the scales by one researcher. Instruments included a Problem Checklist, the Social Support Resources Scale, Coping Strategies Response Cards, the Psychosocial Adjustment to Illness scale and other instruments to measure physical health status. This study found evidence linking social support and coping to adjustment among persons with HIV. Specifically, optimism, control, action and interpersonal coping strategies were associated with low levels of global distress and illness-related psychological distress. Action coping (a problem-focused coping strategy) was the most strongly related to low levels of distress. Higher levels of social support were associated with better subjective health status and illness-related social adjustment; however, this relationship was only evident at the asymptomatic stage. Limitations of this study are reflected in the convenience sampling technique used to obtain subjects which excluded HIV positive women. Additionally, the sample obtained represented a discrete geographical location and was not representative of other regional areas.

Holahan et al. (1995) investigated social support, coping and depressive symptoms in a late-middle aged sample of patients reporting cardiac illness. A nonrandom sampling of 615 individuals diagnosed with chronic cardiac illness ($N = 325$), acute cardiac illness ($N = 71$) and 219 healthy controls participated in a 1-year predictive study. Subjects were

administered the Life Stressors and Social Resources Inventory scale, the Coping Responses Inventory scale, the Health and Daily Living Form, and depression was assessed with an index from the Research Diagnostic Criteria. Subjects who agreed to participate in the study were administered the instruments twice, the second time, 1 year from the first. Major findings of the study suggested that women, overall, cope more poorly with cardiac illness than men, and at 1-year follow-up, displayed more depressive symptoms than men. Positive social support was predictive of fewer depressive symptoms overall, but negative social support in the form of criticism and conflict, was as damaging to adjustment as the positive aspects were beneficial.

The authors of this study were careful to ensure the demographic variables of this population were reflective of the population at large. This enhanced the study's generalization to other cardiac patients throughout the United States. However, the instruments administered did not control for baseline personality factors such as neuroticism. Patient perception of disability and other factors could vary considerably from one person to another. Future research using this model could be strengthened by controlling for personality factors.

CHAPTER III

METHODOLOGY

This chapter reviews the methodology used in this study. The purpose of this study was to investigate the relationship between social support and coping and their effect on surgical recovery in an outpatient setting. The hypothesis for this study stated patients with greater levels of social support would cope more effectively with their outpatient surgery and, thus, recover more rapidly.

Research Design

A descriptive design was utilized in this study to investigate the relationship between social support and coping in elderly patients undergoing outpatient surgery. The variables under study included the level of social support (independent variable) and coping (dependent variable). This was a pretest-posttest descriptive design with the first administration of the instruments given while the subject was in the hospital for preoperative teaching. The second administration followed 3 to 5 days postoperatively.

Population and Sample

This study was conducted at a large teaching hospital in southern California. A convenience sample consisting of two males, 65 and 76 years of age, were selected for inclusion. The surgical procedures performed on these subjects were respectively a hernia repair and a laparoscopic cholecystectomy. Subjects considered for inclusion in this study were: (a) outpatient surgery patients without major complications, (b) patients who could read, write, and speak English, and (c) patients with mild to moderate chronic illnesses as evidenced by their eligibility for outpatient surgery, excluding insulin dependent diabetes and chronic obstructive pulmonary disease (COPD). Patients who developed major complications following surgery were dropped from the study. A total of nine subjects met the inclusion criteria, five subjects agreed to participate, and of those, two completed the study.

Procedure

Initial subject contact occurred in the surgery clinic at the southern California hospital during the outpatient presurgery work-up. It was believed that if the researcher approached the potential subject personally, his willingness to participate in the study would be greater. During this initial contact, the potential subject was told about the research project and his

participation solicited. Information given included the name of the principal researcher, the nature of the study (descriptive), who would collect the data and when, the time involved in both the pretest interview and posttest telephone interview, and information on informed consent (Appendix A). Once the subject's written consent was obtained, he was given an opportunity to ask questions and receive clarification on any issues. The subject was told the first two sections of the three part questionnaire consisted of the Jalowiec Coping Scale (JCS) and Norbeck Social Support Questionnaire (NSSQ). The JCS instrument solicited information about his coping style and the NSSQ asked questions about his social support network. The subject was then instructed to score the questionnaire in a predictive manner, where applicable, in light of his impending surgery. Prior to leaving the clinic the subject's telephone number was obtained and he was given a copy of the instruments to use during the follow-up telephone interview. Three to 5 days after his surgery, the subject was contacted at home and the two instruments were re-administered along with the demographic questionnaire. During this interview the subject was asked to score his responses based on his current situation. After all the data were collected, the subject was thanked for his participation in the research process and an offer made to send him an abstract of the study.

Human Subjects

The Standardized Protocol for the Protection of Human Subjects was completed and approval obtained to proceed with the study. The approval process included both San Diego State University and the study hospital in southern California (Appendix D). Subjects approved for outpatient surgery, and who met the selection criteria, were approached for inclusion in the study between February and March 1997. Subjects who agreed to participate were advised of their human subject rights and written consent obtained. The potential risks of emotional distress due to the data collection process and fatigue from the recuperative process were emphasized. Subjects' freedom to withdraw from the study at any time was emphasized prior to the commencement of data collection procedures. Data collection tools were coded by number and secured at the researcher's residence.

Instrumentation

Three tools were used in this study consisting of two self-administered scales and a demographic questionnaire. The scales were the NSSQ and the JCS. The demographic questionnaire was designed specifically for this study and solicited information regarding the subject's medical history, current living conditions, and recovery status from surgery (Appendix E).

Norbeck Social Support Questionnaire (NSSQ)

The NSSQ was designed to measure multiple dimensions of social support based on Kahn's (1979) definition of social support. The instrument has three main variables: total function, total network, and total loss, each with three subscales. Two questions were developed to measure each of the functional properties of social support — affect, affirmation, and aid. The provision of social support is measured by three network properties: the number in the network, the duration of relationships, and the frequency of contact with network members. Since this instrument is intended for clinical populations, health care providers are included among the possible categories of network membership.

The NSSQ uses a format consisting of a series of half pages containing eight questions that visually align with the subject's personal network list. After a network list is made, the subject is asked to respond to a series of questions by placing a numbered rating from a 5-point Likert scale on the appropriate line. Point one (1) on the Likert scale represents "not at all" and point five (5) represents "a great deal." The subject's ratings for each network member are added to determine the score of each of the first eight questions. Scores for each functional component and the network properties are derived from the ratings made by the subject. Descriptive data can be calculated for the network as a whole and for specific subscales. Question 9 asks the subject if he has had any losses in his/her personal network. The

instrument requires an average of 10 minutes to complete (range of 5 to 20 minutes).

In three studies of nursing students, internal consistency reliability was measured by Cronbach's alpha and consisted of .97, .96, and .89, respectively (Norbeck, Lindsey, & Carrieri, 1983). Social desirability response (response bias) was not present since the correlations were not significant. Test-retest (re-test 1 week later) reliability of functional items and network property items was .85 to .92 and was established using male and female graduate nursing students during phase 1 testing.

In phase 2 testing, correlations between the first test and a 7-month follow-up ranged from .58 to .78 indicating a moderate degree of stability over time. This was lower than the 1-week test-retest correlations of .85 to .92 in phase one (Norbeck et al., 1983).

Concurrent validity at moderate levels was demonstrated by administering the NSSQ and the Cohen and Lazarus Social Support Questionnaire to 42 of the graduate students. Correlations ranged from -.44 to .56 among the subscales. Based on the extensive testing of this instrument and its broad application, the NSSQ was selected for inclusion in this study.

Jalowiec Coping Scale (JCS)

Psychometric support for the revised JCS was provided by 26 studies (Jalowiec and 25 other investigators) (Jalowiec, 1995). Homogeneity

reliability (Cronbach alphas based on unpublished results of 24 JCS studies) was reported at: total use = .86; total effectiveness = .91. The three strongest subscales for both use/effectiveness were confrontive, evasive, and optimistic. Test-retest reliability at intervals of 3, 6, 9 and 12 months ranged from .56-.69 (mean = .61) for total use scores and .43-.63 (mean = .52) for total effectiveness scores.

Content validity was supported by the broad literature and empirical base from which items were drawn, the large number of items to measure coping, and the inclusion of diverse cognitive and behavioral coping strategies (Jalowiec, 1995). Using three judges, the Content Validity Index for the 8 subscales was .85 showing support for relevance of items to each subscale. Construct validity was established using 25 nurse researchers. The nurse researchers were asked to classify the 60 items into 8 subscales. Overall agreement for the 8 subscales was 75%. Criterion and concurrent/predictive validity is also reported (Jalowiec, 1995).

This instrument was selected for inclusion in this study because of its simple presentation style and relative expediency in filling it out. The population under investigation is elderly and in mild to moderate physical distress. This tool is relevant for this sample of elderly.

Demographic Questionnaire

The demographic questionnaire included age, marital status, race,

level of education, income category, living arrangement, current medications, current medical conditions, time since discharge from the hospital, types of post-operative complications, the subject's quality of life since surgery and an assessment of the subject's post-surgery physical status. These data provided additional insights into the relationship between the major variables under investigation.

Statistical Analysis

Demographic data were summarized for the subjects ($N = 2$). A descriptive design was used to collect the data. Due to the small sample size a one-tailed *t*-test could not be performed to test the hypothesis, nor could the Pearson Product Moment Correlation Coefficients be used to determine the strength of the relationships between the demographics of the sample and the major variables under investigation. A case study approach was used to discuss the results.

Limitations of the Study

Results of this study were limited to two adult subjects recovering from outpatient surgery. The small sample size does not represent the population studied or permit generalizations beyond the individual subjects. Statistical analysis is virtually impossible with a sample of two. The probability of a Type II error increases with a small sample size and is oftentimes missed

(Polit & Hungler, 1995). A pilot study of 25 subjects was approved by the institution where data were collected, but because patients did not meet the inclusion criteria, or were dropped due to other reasons, only two subjects were able to participate in both the preoperative and postoperative data collection procedures.

CHAPTER IV

RESULTS AND DISCUSSION

The results of this study along with a discussion of other pertinent information will be presented in this chapter. A descriptive design was used to examine social support and coping in two patients undergoing outpatient surgery. The results of this study are presented in a case study format and will describe each subject's social support network and coping styles both preoperatively and postoperatively. Data from two ($N = 2$) ambulatory surgery patients were used for this descriptive study.

Anecdotal Notes

During the 2-month screening process for this study, 45 general surgery preadmission charts were reviewed for potential subjects. Of the records evaluated, a total of nine patients met the basic inclusion criteria. Five subjects consented to participate in the study and took the first administration of the Norbeck Social Support Questionnaire and Jaloweic Coping Scale. Two subjects completed the study.

Of the five original subjects who completed the first administration of the questionnaire, three were subsequently excluded from the study. Two

patients underwent laparoscopic cholecystectomies but experienced complications necessitating hospital admission. The first subject, a 74-year-old widowed male, converted to an open cholecystectomy with exploratory surgery. This patient remained in the hospital 4 days and was discharged home on the 5th postoperative day. Two days after discharge the patient was readmitted for dehydration and remained in the hospital another 4 days. The second subject, a 68-year-old married male, experienced complications as a result of gallstones and converted to an open cholecystectomy. This patient remained in the hospital 5 days postoperatively and once discharged home, did not return to the hospital. The third subject elected to postpone his surgery. Interestingly, during the first questionnaire administration to this subject, he repeatedly expressed disappointment at not being admitted to the hospital and was fearful of a home recovery. He reported a son in his social support network but elected not to include him on the questionnaire. This tool was left blank intentionally.

Four otherwise eligible subjects were excluded from the study prior to obtaining informed consent. One patient agreed to participate but was planning an immediate return to Mexico following surgery. Two patients met the basic criteria, but were scheduled for hospital admission postsurgery. The last patient initially agreed to participate in the study but later changed his mind prior to signing consent forms.

Demographic Characteristics of the Sample

Subject demographic data are presented in Table 1. The study sample consisted of two males (100%). Subject ages were 69 and 76. Both subjects were scheduled for elective abdominal surgery with planned discharges from the hospital within 23 hours and 59 minutes.

Table 1

Demographic Data for Two Subjects

Pt ID ^a	Age	Marital status	Ethnic group	Annual income	Level of education	Surgery elective	Previous elective surgery
1	69	Widowed	Caucasian	\$40,001-50K ^b	H.S. ^c	Yes	Yes
2	76	Married	Hispanic	\$20,001-30K	H.S.	Yes	No

^aPt ID = Patient identification number.

^bK = Thousands of dollars.

^cH.S. = High school.

Case Study 1

Subject was a 69-year-old, widowed male who underwent a laparoscopic right inguinal hernia repair. The subject reported a history of mild cardiac disease and was currently taking Isordil 20 mg OD and one aspirin

OD. Socially, the subject lived in a home along with his 15-year-old grandson. The subject reported four grown children living in outlying cities.

The subject was administered the first two parts of the questionnaire on his preoperative teaching day. Three days postoperatively, the subject was readministered the JCS and NSSQ along with the demographics instrument. The pretest and posttest raw scores of both instruments are displayed in Appendix F.

Social support. The subject scored .76 for total support preoperatively and .74 postoperatively. Norbeck (1995) reports a normative value for this component of the scale as .95 ($SD = .55$). Questions 1 through 4 measured the domain of emotional support and questions 5 and 6 addressed tangible support. In the area of emotional support, the subject had overall scores of .83 preoperatively and .83 postoperatively. Likewise, tangible support measured .62 and .56 (see Table 2 for comparisons). In both administrations of the instrument the subject scored highest in the domain of emotional support. All members of this subject's support system were long-standing in nature (5 years or greater) with most contact occurring on a daily or weekly basis.

Table 2

Proportional Scores of Social Support for Subject 1

Social support	Pretest	Posttest
Emotional	.83	.83
Tangible	.62	.56
Duration	1.00	1.00
Frequency	.83	.83

Coping. Coping scores for the “use” and “effectiveness” subscales were calculated both preoperatively and postoperatively. In the first administration of the “use” subscale, the subject’s overall score was .46; postoperatively it was .39. “Effectiveness” scored .39 and .36, respectively. Additional calculations were made to measure the proportional use of confrontive, evasive, optimistic, fatalistic emotive, palliative, supportant, and self-reliant coping styles, in both the use and effectiveness categories. These data are displayed in Table 3.

Case Study 2

Subject was a 76-year-old male who underwent an outpatient laparoscopic cholecystectomy. He reported a history of hypertension and managed this condition with hydrochlorothiazide (HCTZ) 25 mg OD. Socially, the

Table 3

Proportional Scores of Each Coping Style for Subject 1

Coping use	Pretest	Posttest	Coping effectiveness	Pretest	Posttest
Confrontive	.47	.30	Confrontive	.47	.33
Evasive	.33	.23	Evasive	.18	.21
Optimistic	.74	.85	Optimistic	.70	.70
Fatalistic	.33	.33	Fatalistic	.25	.33
Emotive	.20	.07	Emotive	.07	0
Palliative	.41	.38	Palliative	.43	.38
Supportant	.66	.40	Supportant	.60	.40
Self-reliant	.41	.48	Self-reliant	.43	.43

subject lived in a house with his wife of 33 years and reported having four grown children. None of the children were living in the home at the time of the subject's surgery.

The subject was administered the first two parts of the questionnaire on his preoperative teaching day. He was contacted again on his 3rd postoperative day, but due to pain and fatigue the interview was postponed until the 5th postoperative day. At this time he was administered the JCS, NSSQ and the demographics questionnaire.

Social support. The raw scores of the pretest and posttest for the NSSQ are displayed in Appendix F. The subject scored .83 for total support preoperatively and .83 postoperatively. Again, the normative value for total support is .95 ($SD = .55$) (Norbeck, 1995). Questions 1 through 4 measured the domain of emotional support and questions 5 and 6 addressed tangible support. In the area of emotional support, the subject scored .93 preoperatively and .94 postoperatively. Respectively, tangible support measured .63 and .60 (see Table 4 for comparisons). In both administrations of the instrument, the subject scored highest in emotional support. All members of this subject's support system were long-standing (5 years or greater) with contact between the subject and his children occurring primarily on a monthly basis. Daily contact occurred with his wife.

Table 4

Proportional Scores of Social Support for Subject 2

Social support	Pretest	Posttest
Emotional	.93	.94
Tangible	.63	.60
Duration	1.00	1.00
Frequency	.64	.64

Coping. Coping scores for the "use" and "effectiveness" subscales were calculated both preoperatively and postoperatively. In the first administration of the instrument, the subject scored .51 on the "use" subscale; postoperatively .41. "Effectiveness" scored .38 and .31, respectively. Additional calculations were made to measure the proportional use of various coping styles including confrontive, evasive, optimistic, fatalistic emotive, palliative, supportant, and self-reliant. These calculations included both the use and effectiveness of each coping style. These data are displayed in Table 5.

Discussion

The original premise of this study design was to prospectively measure subjects' social support networks and coping abilities, then compare

Table 5

Proportional Scores of Each Coping Style for Subject 2

Coping use	Pretest	Posttest	Coping effectiveness	Pretest	Posttest
Confrontive	.66	.43	Confrontive	.57	.37
Evasive	.36	.28	Evasive	.18	.15
Optimistic	.67	.70	Optimistic	.52	.56
Fatalistic	.50	.33	Fatalistic	.33	.17
Emotive	.13	.13	Emotive	0	0
Palliative	.43	.29	Palliative	.43	.24
Supportant	.73	.60	Supportant	.67	.53
Self-reliant	.57	.48	Self-reliant	.38	.43

these results with a second, post operative, measurement of the same variables. It was hypothesized that patients with greater levels of social support would cope more effectively with the stress of outpatient surgery. Due to the small sample size and the inability to submit the results to statistical analysis, the relationship between the major variables was not tested. The following observations are offered on a more intuitive level.

Both subjects appeared to have similar patterns in the measurement of their social support and coping scores. Social support scores were high both before and after surgery, and subjects derived more of their support from emotional sources. Both subjects employed a variety of coping strategies both preoperatively and postoperatively. For the most part, both subjects had similar levels of coping use (both pretest and posttest) and coping effectiveness for each coping style. The exception appears to have been the use of "emotive" coping which is characterized by the expression of emotions and/or feelings (Jaloweic, 1995). Both subjects had very low use scores and even lower effectiveness scores. In terms of high use coping styles, interestingly, both subjects used confrontive, optimistic and supportant coping most frequently. Correspondingly, effectiveness scores for each of these coping styles were higher than other coping strategies. Confrontive coping is characterized by constructive problem-solving, optimistic coping by positive thinking, and supportant coping by use of support systems (Jaloweic, 1995). Confrontive scores for both subjects were higher preoperatively as were

supportant scores. This emerging pattern could represent problem-focused coping as a result of dealing with an impending stressor. Folkman and Lazarus (1980) state that in situations where something constructive can be done, and in which more information is needed, higher levels of problem-focused coping occurs. In this case it is possible these patients engaged in problem-focused coping to minimize the impact of surgery such as seeking information, preparing the home for convalescence and mobilizing support systems. Optimistic coping scores in both subjects were higher postoperatively than preoperatively and could suggest subjects had a brighter outlook after the stressor of surgery was behind them. Finally, in terms of response to the overall surgical process, both patients reported incomplete recoveries at the second testing and no improvement as yet in the quality of their lives.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

FOR FURTHER STUDY

Summary

The purpose of this descriptive study was to examine the relationship between social support and coping ability in senior patients undergoing surgery on an outpatient basis. The number of subjects proposed for this study was 25, however only two subjects successfully completed both the preoperative and postoperative questionnaires. Inclusion criteria included male patients 65 years of age or older, without major medical problems, surgery limited to the abdominal area, and discharges to home within 23 hours and 59 minutes.

The data collected in this study provided a description of the changes in each patient's social support network and coping styles preoperatively and postoperatively. It also included demographic information about each subject and their overall response to the outpatient surgical process. Due to the small sample size and the inability to submit the data to statistical analysis, the results of this study were limited to a descriptive nature.

Recommendations for Further Study

This study described the nature of each subject's social support network and coping styles both preoperatively and postoperatively. Although this study is a starting place in understanding the emotional impact outpatient surgery has on the elderly population's ability to cope with this process, much work remains to fully understand these dynamics. With trends in health care reimbursement pointing toward increased use of the outpatient setting, along with an increasingly eligible surgical population, 65 and over, it is imperative for health care professionals to have a thorough understanding of the role social support plays in successful surgical outcomes. A case in point was the one patient who was dropped from this study after his initial testing and subsequent admission to the hospital. In this instance, the patient was eventually discharged home only to be readmitted within 2 days for a readily preventable condition, dehydration.

Although elderly people may physically qualify for outpatient surgery, their physiology along with other social factors may lead to prolonged recoveries and/or complications. It is essential for health care providers to have a thorough understanding of the environment to which the elderly patient is returning, so negative sequelae may be minimized. If health care professionals can develop a method to accurately identify patients at increased risk and appropriately discharge plan for their home recovery, the

success of outpatient surgery may be enhanced. This understanding can be elucidated through additional studies exploring the role social support plays in the elderly patient's ability to cope with outpatient surgery. The following suggestions are made to improve this knowledge base:

1. Replicate the current methodology with a larger sample size over a longer period of time.
2. Future studies examining the effects of social support and coping in elderly outpatient surgical patients should include other types of common surgical procedures.
3. A replication study could also be conducted including equal numbers of each gender and following one surgeon.
4. A similar study could also compare patient outcomes in different settings such as a hospital versus a surgicenter, or an HMO versus a private, for profit hospital.

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APPENDIX A

NORBECK SOCIAL SUPPORT QUESTIONNAIRE

SOCIAL SUPPORT QUESTIONNAIRE

PLEASE READ ALL DIRECTIONS
ON THIS PAGE BEFORE STARTING

Please list each significant person in your life on the right. Consider all the persons who provide personal support for you or who are important to you.

Use only first names or initials, and then indicate the relationship, as in the following example:

	First Name or Initials	Relationship
1.	MARY T.	FRIEND
2.	BOB	BROTHER
3.	M.T.	MOTHER
4.	SAM	FRIEND
5.	MRS. R.	NEIGHBOR

etc.

Use the following list to help you think of the people important to you, and list as many people as apply in your case.

- spouse or partner
- family members or relatives
- friends
- work or school associates
- neighbors
- health care providers
- counselor or therapist
- minister/priest/rabbi
- other

You do not have to use all 24 spaces. Use as many spaces as you have important persons in your life.

WHEN YOU HAVE FINISHED YOUR LIST, PLEASE TURN TO PAGE 2.

© 1980 by Jane S. Norbeck, DNSc
University of California, San Francisco
Revised 1982, 1995

Note: Before use, pages 1-4 should be cut along the dashed center line to allow the response lines for Questions 1-6 to align with the Personal Network list on page 5.

For each person you listed, please answer the following questions by writing in the number that applies.

- 0 = not at all
 1 = a little
 2 = moderately
 3 = quite a bit
 4 = a great deal

Question 1:

How much does this person make you feel liked or loved?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[EMO1]

Question 2:

How much does this person make you feel respected or admired?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[EMO2]

Note: Before use, pages 1-4 should be cut along the dashed center line to allow the response lines for Questions 1-6 to align with the Personal Network list on page 5.

- 0 = not at all
 1 = a little
 2 = moderately
 3 = quite a bit
 4 = a great deal

Question 3:

How much can you confide
 in this person?

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 8. _____
 9. _____
 10. _____
 11. _____
 12. _____
 13. _____
 14. _____
 15. _____
 16. _____
 17. _____
 18. _____
 19. _____
 20. _____
 21. _____
 22. _____
 23. _____
 24. _____
- [EMO3]

Question 4:

How much does this person
 agree with or support your
 actions or thoughts?

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 8. _____
 9. _____
 10. _____
 11. _____
 12. _____
 13. _____
 14. _____
 15. _____
 16. _____
 17. _____
 18. _____
 19. _____
 20. _____
 21. _____
 22. _____
 23. _____
 24. _____
- [EMO4]

Note: Before use, pages 1-4 should be
 cut along the dashed center line to
 allow the response lines for Questions
 1-6 to align with the Personal Network
 list on page 5.

- 0 = not at all
 1 = a little
 2 = moderately
 3 = quite a bit
 4 = a great deal

Question 5:

If you needed to borrow \$10, a ride to the doctor, or some other immediate help, how much could this person usually help?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[AID5]

Question 6:

If you were confined to bed for several weeks, how much could this person help you?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[AID6]

Note: Before use, pages 1-4 should be cut along the dashed center line to allow the response lines for Questions 1-6 to align with the Personal Network list on page 5.

Number _____
Date _____

[PHONE]

PERSONAL NETWORK

Relationship

First Name or Initials

1. _____ [SOU1]
2. _____ [SOU2]
3. _____ [SOU3]
4. _____ [SOU4]
5. _____ [SOU5]
6. _____ [SOU6]
7. _____ [SOU7]
8. _____ [SOU8]
9. _____ [SOU9]
10. _____ [SOU10]
11. _____ [SOU11]
12. _____ [SOU12]
13. _____ [SOU13]
14. _____ [SOU14]
15. _____ [SOU15]
16. _____ [SOU16]
17. _____ [SOU17]
18. _____ [SOU18]
19. _____ [SOU19]
20. _____ [SOU20]
21. _____ [SOU21]
22. _____ [SOU22]
23. _____ [SOU23]
24. _____ [SOU24]

Question 8:

How frequently do you usually have contact with this person? (Phone calls, visits, or letters)

- 5 = daily
4 = weekly
3 = monthly
2 = a few times a year
1 = once a year or less

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____ [FREQCON]

Question 7:

How long have you known this person?

- 1 = less than 6 months
2 = 6 to 12 months
3 = 1 to 2 years
4 = 2 to 5 years
5 = more than 5 years

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____ [DURATION]

PLEASE BE SURE YOU HAVE RATED EACH PERSON ON EVERY QUESTION. GO ON TO THE LAST PAGE.

9. During the past year, have you lost any important relationships due to moving, a job change, divorce or separation, death, or some other reason?

- ☐ 0. No
☐ 1. Yes

[LOSS]

IF YES:

9a. Please indicate the number of persons from each category who are no longer available to you.

- spouse or partner
 family members or relatives
 friends
 work or school associates
 neighbors
 health care providers
 counselor or therapist
 minister/priest/rabbi
 other (specify)

[LOSS1]
 [LOSS2]
 [LOSS3]
 [LOSS4]
 [LOSS5]
 [LOSS6]
 [LOSS7]
 [LOSS8]
 [LOSS9]
 [LOSSNO]
 [LOSSAMT]

9b. Overall, how much of your support was provided by these people who are no longer available to you?

0. none at all
 1. a little
 2. a moderate amount
 3. quite a bit
 4. a great deal

APPENDIX B

JALOWEIC COPING SCALE

JALOWIEC COPING SCALE

This questionnaire is about how you cope with stress and tension, and what you do to handle stressful situations. In particular, I am interested in how you have coped with the stress of:

This questionnaire lists many different ways of coping with stress. Some people use a lot of different coping methods; some people use only a few.

You will be asked two questions about each different way of coping with stress:

Part A

How often have you used that coping method to handle the stress listed above?

For each coping method listed, circle one number in Part A to show how often you have used that method to cope with the stress listed above. The meaning of the numbers in Part A is as follows:

- 0 = never used
- 1 = seldom used
- 2 = sometimes used
- 3 = often used

Part B

If you have used that coping method, how helpful was it in dealing with that stress?

For each coping method that you have used, circle a number in Part B to show how helpful that method was in coping with the stress listed above. The meaning of the numbers in Part B is as follows:

- 0 = not helpful
- 1 = slightly helpful
- 2 = fairly helpful
- 3 = very helpful

If you did not use a particular coping method, then do not circle any number in Part B for that coping method.

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	Seldom Used	Sometimes Used	Often Used	Not Helpful	Slightly Helpful	Fairly Helpful	Very Helpful
1. Worried about the problem	0	1	2	3	0	1	2	3
2. Hoped that things would get better	0	1	2	3	0	1	2	3
3. Ate or smoked more than usual	0	1	2	3	0	1	2	3
4. Thought out different ways to handle the situation	0	1	2	3	0	1	2	3
5. Told yourself that things could be much worse	0	1	2	3	0	1	2	3
6. Exercised or did some physical activity	0	1	2	3	0	1	2	3
7. Tried to get away from the problem for a while	0	1	2	3	0	1	2	3
8. Got mad and let off steam	0	1	2	3	0	1	2	3
9. Expected the worst that could happen	0	1	2	3	0	1	2	3
10. Tried to put the problem out of your mind and think of something else	0	1	2	3	0	1	2	3
11. Talked the problem over with family or friends	0	1	2	3	0	1	2	3
12. Accepted the situation because very little could be done	0	1	2	3	0	1	2	3
13. Tried to look at the problem objectively and see all sides	0	1	2	3	0	1	2	3
14. Daydreamed about a better life	0	1	2	3	0	1	2	3
15. Talked the problem over with a professional person (such as a doctor, nurse, minister, teacher, counselor)	0	1	2	3	0	1	2	3
16. Tried to keep the situation under control	0	1	2	3	0	1	2	3
17. Prayed or put your trust in God	0	1	2	3	0	1	2	3
18. Tried to get out of the situation	0	1	2	3	0	1	2	3
19. Kept your feelings to yourself	0	1	2	3	0	1	2	3
20. Told yourself that the problem was someone else's fault	0	1	2	3	0	1	2	3
21. Waited to see what would happen	0	1	2	3	0	1	2	3
22. Wanted to be alone to think things out	0	1	2	3	0	1	2	3
23. Resigned yourself to the situation because things looked hopeless	0	1	2	3	0	1	2	3

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	Seldom Used	Sometimes Used	Often Used	Not Helpful	Slightly Helpful	Fairly Helpful	Very Helpful
24. Took out your tensions on someone else	0	1	2	3	0	1	2	3
25. Tried to change the situation	0	1	2	3	0	1	2	3
26. Used relaxation techniques	0	1	2	3	0	1	2	3
27. Tried to find out more about the problem	0	1	2	3	0	1	2	3
28. Slept more than usual	0	1	2	3	0	1	2	3
29. Tried to handle things one step at a time	0	1	2	3	0	1	2	3
30. Tried to keep your life as normal as possible and not let the problem interfere	0	1	2	3	0	1	2	3
31. Thought about how you had handled other problems in the past	0	1	2	3	0	1	2	3
32. Told yourself not to worry because everything would work out fine	0	1	2	3	0	1	2	3
33. Tried to work out a compromise	0	1	2	3	0	1	2	3
34. Took a drink to make yourself feel better	0	1	2	3	0	1	2	3
35. Let time take care of the problem	0	1	2	3	0	1	2	3
36. Tried to distract yourself by doing something that you enjoy	0	1	2	3	0	1	2	3
37. Told yourself that you could handle anything no matter how hard	0	1	2	3	0	1	2	3
38. Set up a plan of action	0	1	2	3	0	1	2	3
39. Tried to keep a sense of humor	0	1	2	3	0	1	2	3
40. Put off facing up to the problem	0	1	2	3	0	1	2	3
41. Tried to keep your feelings under control	0	1	2	3	0	1	2	3
42. Talked the problem over with someone who had been in a similar situation	0	1	2	3	0	1	2	3
43. Practiced in your mind what had to be done	0	1	2	3	0	1	2	3
44. Tried to keep busy	0	1	2	3	0	1	2	3
45. Learned something new in order to deal with the problem	0	1	2	3	0	1	2	3
46. Did something impulsive or risky that you would not usually do	0	1	2	3	0	1	2	3

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	Seldom Used	Sometimes Used	Often Used	Not Helpful	Slightly Helpful	Fairly Helpful	Very Helpful
47. Thought about the good things in your life	0	1	2	3	0	1	2	3
48. Tried to ignore or avoid the problem	0	1	2	3	0	1	2	3
49. Compared yourself with other people who were in the same situation	0	1	2	3	0	1	2	3
50. Tried to think positively	0	1	2	3	0	1	2	3
51. Blamed yourself for getting into such a situation	0	1	2	3	0	1	2	3
52. Preferred to work things out yourself	0	1	2	3	0	1	2	3
53. Took medications to reduce tension	0	1	2	3	0	1	2	3
54. Tried to see the good side of the situation	0	1	2	3	0	1	2	3
55. Told yourself that this problem was really not that important	0	1	2	3	0	1	2	3
56. Avoided being with people	0	1	2	3	0	1	2	3
57. Tried to improve yourself in some way so you could handle the situation better	0	1	2	3	0	1	2	3
58. Wished that the problem would go away	0	1	2	3	0	1	2	3
59. Depended on others to help you out	0	1	2	3	0	1	2	3
60. Told yourself that you were just having some bad luck	0	1	2	3	0	1	2	3

If there are any other things you did to handle the stress mentioned at the beginning, that are not on this list, please write those coping methods in the spaces below. Then circle how often you have used each coping method, and how helpful each coping method has been.

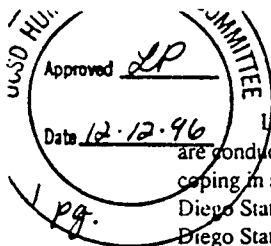
61.	1	2	3	0	1	2	3
62.	1	2	3	0	1	2	3
63.	1	2	3	0	1	2	3

APPENDIX C

CONSENT FORMS AND SUBJECT'S

BILL OF RIGHTS

96/222X



VETERANS AFFAIRS MEDICAL CENTER - SAN DIEGO
 CONSENT TO ACT AS A RESEARCH SUBJECT

Lee Sheehan, RN, the Principal Investigator, and Marty Shively, PhD, RN, the Co-Investigator, are conducting a research study to find out more about the relationship between social support and coping in senior patients undergoing outpatient surgery. Lee Sheehan is a graduate nursing student at San Diego State University, and Dr. Shively is a nurse researcher at the La Jolla VA and faculty member in San Diego State University's Graduate Nursing Department. You have been asked to take part in this study because you are undergoing outpatient surgery and are 65 years of age or older. There will be approximately 25 subjects from this site.

If you agree to be in this study, the following will happen to you:

1. You will complete the first two parts of a three-part questionnaire immediately upon agreement to participate in this study. The first part, the Norbeck Social Support Questionnaire measures your social support and the second part, the Jalowiec Coping Scale, evaluates your coping style. The third part, a demographic questionnaire, asks personal questions about you which may assist in interpreting the results of the other questionnaire parts. It will take approximately 20 minutes to complete the first two parts.
2. A researcher will contact you via telephone between your 3rd and 5th post-operative day to re-administer the questionnaire including the third part, the demographic questionnaire. It will take approximately 30 minutes to complete this interview.

Risks or discomforts may include emotional distress in considering your social support network and/or coping style, and possible fatigue in completing the questionnaire. Potential emotional distress related to the evaluation of your social support may result as one contemplates the loss of loved ones over the life cycle. Emotional distress related to the evaluation of your coping style may result from the personal conflict you feel between how you would like to cope and how you actually cope. To minimize these risks, you may discontinue participation in this study either temporarily or permanently. Also, all information obtained will be completely anonymous thereby avoiding subject embarrassment.

There may or may not be any direct benefits to you from this study. The investigators, however, may learn more about the role social support plays in the patient's ability to cope with outpatient surgery. There are additional possible benefits to society and health care professionals by providing a better understanding of the role social support plays in the patient's ability to cope with outpatient surgery. This information may lead to better surgical outcomes by providing documented evidence of the need to thoroughly assess the senior patient's social support network during the discharge planning phase of care. In turn, this information may impact the way health care resources are currently allocated for home care. Personal benefits to you may include the knowledge you receive from your self-evaluation of your social support network and coping style. You will not be paid for participating in this research study.

Lee Sheehan, RN has explained this study to you and answered your questions. If you have other questions or research related procedures, you may reach Dr. Marty Shively at 552-8585 (ext. 3493) or Dr. Catherine Loveridge at 619/594-3423. Dr. Loveridge is Ms. Sheehan's graduate advisor and is overseeing her academic work in this study.

Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without jeopardy to the medical care you will receive at this institution.

Research records will be kept confidential to the extent provided by law.

You have received a copy of this consent document to keep and "The Experimental Subject's Bill of Rights." If you have any questions regarding your rights as a human subject and participant in this study, you may call the San Diego State University Committee on Protection of Human Subjects at (619) 594-6622, or the University of California, San Diego Human Subjects Committee at 619/534-4520.

COMMITTEE ON PROTECTION OF
 HUMAN SUBJECTS
 APPROVED BY 3ML
 DATE 12/17/97
 SAN DIEGO STATE UNIVERSITY

You agree to participate.

Subject's Signature

Date

Witness

UCSD1.doc

VA Department of Veterans Affairs	VA RESEARCH CONSENT FORM
-----------------------------------	--------------------------

Subject Name: _____ Date: _____

Title of Study: The Relationship Between Social Support & Coping in Patients Undergoing Outpatient Surgery.

Principal Investigator: Lee A. Sheehan, RN VAMC: _____

RESEARCH SUBJECTS' RIGHTS: I have read or have had read to me all the above.

Lee Sheehan, RN has explained the study to me and answered all of my questions. I have been told of the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty or loss of VA or other benefits to which I am entitled.

The results of this study may be published, but my records will not be revealed unless required by law.

In case there are medical problems or questions, I have been instructed that I can call Dr. Marty Shively at 619/552-8585 ext. 3493 during the day and Lee Sheehan, RN at 619/753-2590 after hours. If any medical problems occur in connection with this study, the VA will provide emergency care.

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

Subject's Signature

Date

Signature of Subject's Representative*

Subject's Representatives

Signature of Witness

Witness (print)

Signature of Investigator

*Only required if subject not competent.

IF MORE THAN ONE PAGE IS USED EACH PAGE (VAF 10-1086A) MUST BE CONSECUTIVELY NUMBERED AND SIGNED.

UNIVERSITY OF CALIFORNIA, SAN DIEGO

UCSD

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SANTA BARBARA • SANTA CRUZ

HUMAN SUBJECTS PROGRAM OFFICE

9500 GILMAN DRIVE
 LA JOLLA, CALIFORNIA 92093-0052
 (619) 534-4520
 (619) 534-5725 (FAX)

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

The faculty and staff of the University of California, San Diego wish you to know:

Any person who is requested to consent to participate as a subject in a research study involving a medical experiment, or who is requested to consent on behalf of another, has the right to:

1. Be informed of the nature and purpose of the experiment.
2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be used.
3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.
4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.
5. Be given a disclosure of any appropriate alternative procedures, drugs, or devices that might be advantageous to the subject, and their relative risks and benefits.
6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.
7. Be given an opportunity to ask any questions concerning the experiment or the procedures involved.
8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time, and the subject may discontinue participation in the medical experiment without prejudice.
9. Be given a copy of a signed and dated written consent form when one is required.
10. Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

If you have questions regarding a research study, the researcher or his/her assistant will be glad to answer them. You may seek information from the Human Subjects Committee - established for the protection of volunteers in research projects - by calling (619) 534-4520 from 8:00 a.m. to 4:30 p.m., Monday through Friday, or by writing to the above address. Mail Code 0052.

RIGHTS.BIL

APPENDIX D

LETTERS OF PERMISSION



Committee on Protection
of Human Subjects
San Diego State University
5500 Campanile Drive
San Diego CA 92182-1643

(619) 594-6622 FAX: (619) 594-4109

January 10, 1997

Lee A. Sheehan
1190 Encinitas Blvd., #129
Encinitas, CA 92024

Study: 96-12-384X
Title: *The Relationship Between Social Support and Coping in Patients Undergoing Outpatient Surgery*
Subject: CPHS Approval

Dear Ms. Sheehan:

This letter is to inform you that the conditions of your approval have been addressed. In addition, the modification that you requested has been approved. The modification to your protocol includes the addition of a pretest measurement interval along with minor changes to the item used to garner years of education on the demographic questionnaire.

Approval for this research expires on December 17, 1997 and applies to the conditions and procedures described in your protocol. Approval carries with it the understanding that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification to the protocol without prior approval of the Committee.

Enclosed is a copy of the informed consent agreement. This agreement bears the Committee's stamp of approval. Changes may not be made to this document without prior review and approval by the Committee. You are required to keep signed copies of the consent agreement for three years after your project has been completed or terminated.

Your project is subject to annual review by the Committee. Approximately eight weeks before approval expires, we will send you an "Annual Report of Progress and Request for Review" form. This must be reviewed and approved by the Committee prior to December 17, 1997. As it is your responsibility to assure current approval of your project, please notify the CPHS office if you do not receive an annual review form.

In accordance with our Multiple Project Assurance for Protection of Human Research Subjects, we are supplying you with a copy of our Assurance document. Please contact our office (594-8622) if you would like access to copies of 45 CFR 46, the Belmont Report, and/or any other relevant policies and guidelines related to the involvement of human subjects in research.

Sincerely,

A handwritten signature in cursive script, reading "Camille N. Ross".

Camille N. Ross
Research Services Coordinator

enc: Informed Consent Agreement and Assurance Document
c: Director, School of Nursing
C. Loveridge

961222X



UNIVERSITY OF CALIFORNIA, SAN DIEGO
HUMAN SUBJECTS COMMITTEE

TO: Dr. Marty Shivley Mailcode: 9118
RE: Project #961222X
The Relationship between Social Support and Coping in
Patients Undergoing Outpatient Surgery

Dear Dr. Shivley:

The above-referenced project was reviewed and approved by one of this institution's Institutional Review Boards in accordance with the requirements of the Code of Federal Regulations on the Protection of Human Subjects (45 CFR 46), including its relevant Subparts.

Date of IRB review and approval: December 12, 1996

Lucille Pearson
Lucille Pearson, Director
Human Subjects Program
UCSD 0052
La Jolla, CA 92093-0052
(619) 534-4520

PERMISSION FOR USE OF JCS

PERMISSION IS HEREBY GRANTED TO

Lee A. Sheehan

TO USE THE JALOWIEC COPING SCALE
IN A STUDY OR PROJECT

Anne Jalowiec

ANNE JALOWIEC, RN, PHD
LOYOLA UNIVERSITY OF CHICAGO

DATE: 9-6-46

Appendix C

Request Form

I request permission to copy the 1995 revised version of the Norbeck Social Support Questionnaire (NSSQ) for use in research in a study entitled:

The Relationship Between Social Support
and Coping in the Elderly Undergoing
Outpatient Surgery

I am aware that the revised 1995 Scoring Instructions should be used with this version of the NSSQ.

Lee A. Sheehan 27 Sep 96
 Signature of Investigator Date

Lee A. Sheehan
 Typed or Printed Name of Investigator

Graduate Nursing Student
 Position

San Diego State U., San Diego, CA
 Institution

1190 Encinitas Blvd, Apt 129
 Address

Encinitas, CA 92024
 City, State, (Country), ZIP Code

Permission is hereby granted to copy the NSSQ for use in the research described above.

Jane S. Norbeck
 Jane S. Norbeck

October 3, 1996
 Date

Please send or fax two signed copies of this form to:

Jane S. Norbeck, RN, DNSc
 Professor and Dean
 School of Nursing, Box 0604
 University of California, San Francisco
 501 Parnassus Avenue
 San Francisco, CA 94143-1604
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APPENDIX E

DEMOGRAPHICS QUESTIONNAIRE

DEMOGRAPHICS QUESTIONNAIRE

WHAT IS YOUR:

1. AGE:
2. MARITAL STATUS:
3. ETHNIC GROUP:
4. LEVEL OF EDUCATION: () less than H.S. grad; () H.S. grad; () some college;
() college grad; () some Masters work; () Masters Degree; () beyond Masters Degree
5. What is your yearly income level? () less than \$10,000 () \$10,000-\$20,000;
() \$20,001-\$30,000; () \$30,001-\$40,000; () \$40,001-\$50,000; () greater than \$50,000
6. Is this your first surgical procedure? (Y or N)
7. Was this surgery elective? (Y or N) Please give specifics: _____

8. Was this surgery done as an emergency? (Y or N)
9. Did you experience post-operative complications? (Y or N) If yes, please state:

10. How many days have you been home since your surgery? _____ (Days)
11. What is your current living arrangement (house, apt., retirement community, etc.)
and time in this residence? _____
12. Do you have a medical condition for which you are receiving treatment? (Y or N)
If yes, please list your medical condition(s). _____

13. Are you currently taking prescribed medication? (Y or N) If yes, please identify the
medication, dosage and times taken per day. _____

14. How has your surgical procedure affected your health status? (1) there is an
improvement in my health; (2) my health is about the same; (3) my health has diminished
since surgery.
15. How would you rate your recovery from surgery today? (1) complete (2) incomplete

Thank you very much for taking the time to participate in this study.

Lee Sheehan, RN, MS(c)

APPENDIX F

RAW SCORES FOR THE NORBECK SOCIAL SUPPORT QUESTIONNAIRE AND THE JALOWEIC COPING SCALE

RAW SCORES FOR THE NSSQ AND JCS

Subject No. 01

No. In Network - 6

Type of Group: Same Day Surgical Patient (RIH)

NORBECK SOCIAL SUPPORT QUESTIONNAIRE

Pretest

	Relationship	Ques 1	Ques 2	Ques 3	Ques 4	Ques 5	Ques 6	Person Totals (Ques 1-6)	Ques 7	Ques 8
1	Son	3	3	3	3	4	1	17	5	3
2	Son	2	1	1	1	2	1	8	5	4
3	Daughter	4	4	4	4	4	1	21	5	4
4	Daughter	4	4	4	4	4	1	21	5	4
5	Grandson	4	4	4	4	2	3	21	5	5
6	Friend	3	4	4	4	4	3	21	5	5

Posttest

	Relationship	Ques 1	Ques 2	Ques 3	Ques 4	Ques 5	Ques 6	Person Totals (Ques 1-6)	Ques 7	Ques 8
1	Son	3	3	3	3	3	1	16	5	3
2	Son	2	1	1	2	1	1	8	5	4
3	Daughter	4	4	4	4	4	1	21	5	4
4	Daughter	4	4	4	4	4	1	21	5	4
5	Grandson	4	4	4	4	3	3	22	5	5
6	Friend	3	4	4	3	3	2	19	5	5

JALOWEIC COPING SCALE RAW SCORES

	Confrontive (10 items)	Evasive (13 items)	Optimistic (9 items)	Fatalistic (4 items)	Emotive (5 items)	Palliative (7 items)	Supportant (5 items)	Self-Reliant (7 items)
Pretest	14	10	20	4	3	11	10	11
Posttest	9	9	23	4	1	8	6	10
	Confrontive (10 items)	Evasive (13 items)	Optimistic (9 items)	Fatalistic (4 items)	Emotive (5 items)	Palliative (7 items)	Supportant (5 items)	Self-Reliant (7 items)
Pretest	14	7	19	3	1	9	9	9
Posttest	10	8	19	4	0	8	6	9

RAW SCORES FOR THE NSSQ AND JCS

Subject No. 02

No. In Network - 5

Type of Group: Same Day Surgical Patient (Lap Chole)

NORBECK SOCIAL SUPPORT QUESTIONNAIRE

Pretest		Ques 1	Ques 2	Ques 3	Ques 4	Ques 5	Ques 6	Person Totals (Ques 1-6)	Ques 7	Ques 8
1	Wife	4	4	4	4	4	4	24	5	5
2	Daughter	4	4	4	4	4	2	22	5	3
3	Son	4	3	1	2	1	0	11	5	2
4	Daughter	4	4	4	4	4	1	21	5	3
5	Son	4	4	4	4	4	1	21	5	3

Posttest

Relationship	Ques 1	Ques 2	Ques 3	Ques 4	Ques 5	Ques 6	Person Totals (Ques 1-6)	Ques 7	Ques 8
1 Wife	4	4	4	4	4	4	24	5	5
2 Daughter	4	4	4	4	4	1	21	5	3
3 Son	4	3	2	2	1	0	12	5	2
4 Daughter	4	4	4	4	4	1	21	5	3
5 Son	4	4	4	4	4	1	21	5	3

JALOWEIC COPING SCALE RAW SCORES

	Confrontive (10 items)	Evasive (13 items)	Optimistic (9 items)	Fatalistic (4 items)	Emotive (5 items)	Palliative (7 items)	Supportant (5 items)	Self-Reliant (7 items)
Use Subscale								
Pretest	20	14	18	6	2	9	11	12
Posttest	13	11	19	4	2	6	9	10
Effectiveness Subscale								
Pretest	17	7	14	4	0	9	10	8
Posttest	11	6	15	2	0	5	8	9

ABSTRACT

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The purpose of this study was to describe the relationship between social support and coping in patients undergoing outpatient surgery who were 65 years of age, or older. Patients who met the inclusion criteria were those who underwent surgery in the abdominal area and were discharged to home within 23 hours and 59 minutes. Subject 1 underwent a laparoscopic right inguinal hernia repair and Subject 2 had a laparoscopic cholecystectomy. The working hypothesis for this study assumed patients with greater levels of social support would cope more effectively with outpatient surgery and thus, recover more rapidly. However, due to the small sample size the hypothesis was not submitted to statistical analysis.

Patients who met the inclusion criteria completed the Norbeck Social Support Questionnaire (NSSQ) and the Jaloweic Coping Scale (JCS) pre-surgery in the ambulatory care setting. Once the surgical procedures were performed and the patients discharged to home, the subjects were contacted by telephone and re-administered the NSSQ, the JCS, and a demographics questionnaire within 3 to 5 days postsurgery.

Both subjects appeared to have similar patterns in the measurement of their social support and coping scores. Social support scores were high both before and after surgery, and subjects derived most of their support from

emotional sources. Coping strategies preoperatively and postoperatively were similar in use levels and styles for both subjects. Emotive coping was the exception for both subjects and was characterized by low use scores and even lower effectiveness scores. Both subjects used confrontive, optimistic and supportant coping the most, and their effectiveness scores for these coping styles were equally high. Confrontive scores were high preoperatively for both subjects and suggest a problem-focused approach to stress reduction. Higher optimistic scores by both subjects postoperatively suggest a brighter outlook after the stressor of surgery was behind them. Neither patient reported an improvement in the quality of their lives in this immediate postoperative period.